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29 June 2010

The Honorable Eric K. Shinseki
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

My staff recently informed me that St. Louis VAMC – John Cochran will soon notify more than 1800 veterans from our area that, while "infinitesimal", there is a possibility that they may have been exposed to HIV or Hepatitis through the negligence of VAMC staff. Apparently, for nearly a year, those responsible for doing so failed to properly clean the dental equipment utilized at John Cochran.

The reason given by the acting director of St. Louis VAMC for this failure is that a growing number of veterans have been utilizing dental services and that the organization simply got "too busy." While I can certainly understand an occasional lapse caused by an overload of patients, I find it hard to believe that a breakdown that persisted for nearly twelve months does not represent a systemic failure of both staff and management.

I would appreciate having the following answered:

- This failure was first discovered during a 9 – 12 March inspection, why did the Veterans Administration wait until 28 June to notify Missouri and Illinois congressional offices?

- What personnel/positions at John Cochran will be held responsible for this lapse? What will be the consequences?

- While an "infinitesimal" risk of infection exists, what ongoing support and services will be provided, free of charge, to affected veterans?

- Despite the VA's assurance of a significantly small risk posed by this failure to the veterans affected, what plan does the VA have in place should a veteran discover he/she is infected with HIV or Hepatitis?

- Has the VA done a comprehensive review of John Cochran to ensure that similar lapses are not occurring in other areas?

- What preventative measures will St. Louis VAMC be taking and the Department overall to ensure that this does not occur again?

If it were discovered that, by failing to follow procedure for nearly a year, a private sector hospital or dental practice put the health of their patients at risk, the public would rightly expect those responsible to be disciplined or even dismissed. I trust that the staff and management of John Cochran are held to no less a standard.

I would like regular updates over the next few months as the VA works with the affected veterans. This should include (consistent with privacy requirements) notification if any veteran(s) were actually infected as a consequence of this failure in medical care.

There are no doubt a large number of dedicated and hardworking folks at St. Louis VAMC, many of whom are veterans themselves, who daily seek to provide our nation's veterans with the best care possible. However, the excuse of the facility being "too busy" and a persistent failure to follow appropriate guidelines is simply not good enough for those Americans who have put themselves in harm's way to protect our country.

I look forward to your prompt reply to my questions.

Sincerely,

W. Todd Akin
Member of Congress

WTA:fk

CC: Acting Director, St. Louis VAMC – John Cochran